Department of Veterans Affairs

# VA RESEARCH CONSENT FORM HIPAA Revocation

Subject Name: _____ Date _____

Title of Study: H02-131 Telemedicine Intervention to Improve Depression Care in Rural CBOCs

Principal Investigator: Dean Robinson, M.D. VAMC: Shreveport, LA

## Revocation of Authorization for Release of Protected Health Information for Research Purposes

TO: _____ (Dean Robinson, M.D.)

I revoke my previous authorization for you to use or disclose my protected health information as part of your study.

I understand that the research team will continue to use and disclose health information about me that has already been collected. However, they will only use and disclose the information only for the reasons discussed in the Consent Form I signed when I joined the study.

I understand the revoking this authorization may mean that my participation in the study will also end. It will not affect my rights as a VHA patient, including health care I may need when I am no longer in the study.

Signed:

_____
Participant Signature

_____
Date